

		FOR OHF USE					

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**2003**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2003)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0010330</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Rehab &amp; Care Ctr-Jackson County</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>12/01/02</u> to <u>11/30/03</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>1441 North 14th Street</u> <u>Murphysboro</u> <u>62966</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>Jackson</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____ (Type or Print Name) <u>31</u> (Title) _____	
<b>Telephone Number:</b> <u>618-684-2136</u> <b>Fax #</b> <u>618-684-5170</u>		<b>Paid Preparer</b> (Signed) _____ (Date) _____ (Print Name and Title) <u>Mark W. Dallas</u> <u>CPA, Partner</u> (Firm Name & Address) <u>Kerber, Eck, Braeckel LLP</u> <u>1116 W. Main St., Carbondale, IL 62903</u> (Telephone) <u>618-529-1040</u> <b>Fax #</b> <u>618-549-2311</u>	
<b>IDPA ID Number:</b> <u>37-6001092-004</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> 201 S. Grand Avenue East Springfield, IL 62763-0001 <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> _____			
<b>Type of Ownership:</b>			
<input type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input type="checkbox"/> <b>PROPRIETARY</b> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input checked="" type="checkbox"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input checked="" type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Mark Dallas</u> <b>Telephone Number:</b> <u>618-529-1040</u>			

## STATE OF ILLINOIS

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Facility Name & ID Number Rehab & Care Ctr-Jackson County# 0010330 Report Period Beginning: 12/01/02 Ending: 11/30/03

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>202</u>	Skilled (SNF)	<u>202</u>	<u>73,730</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>202</u>	TOTALS	<u>202</u>	<u>73,730</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>5,653</u>	<u>2,750</u>	<u>8,162</u>	<u>16,565</u>	8
9	SNF/PED					9
10	ICF	<u>29,102</u>	<u>15,033</u>	<u>89</u>	<u>44,224</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>34,755</u>	<u>17,783</u>	<u>8,251</u>	<u>60,789</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 82.45%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started     /    /    

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date     /    /     NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 54 and days of care provided 8,131

Medicare Intermediary \_\_\_\_\_

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☐ NO ☐Tax Year: \_\_\_\_\_ Fiscal Year: 11/30/03

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

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Facility Name &amp; ID Number      Rehab &amp; Care Ctr-Jackson County      #      0010330      Report Period Beginning:      12/01/02      Ending:      11/30/03

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>A. General Services</b>											
1	Dietary	422,487	21,945	13,296	457,728		457,728		457,728			1
2	Food Purchase		232,079		232,079		232,079	(1,548)	230,531			2
3	Housekeeping	224,085	28,027	30,938	283,050		283,050		283,050			3
4	Laundry	176,513	13,136	1,535	191,184		191,184		191,184			4
5	Heat and Other Utilities			215,168	215,168		215,168		215,168			5
6	Maintenance	63,063	19,812	74,076	156,951		156,951		156,951			6
7	Other (specify):*											7
8	<b>TOTAL General Services</b>	886,148	314,999	335,013	1,536,160		1,536,160	(1,548)	1,534,612			8
	<b>B. Health Care and Programs</b>											
9	Medical Director			38,280	38,280		38,280		38,280			9
10	Nursing and Medical Records	3,209,083	77,547	27,300	3,313,930		3,313,930		3,313,930			10
10a	Therapy	159,328	4,381	47,334	211,043		211,043		211,043			10a
11	Activities	126,638			126,638		126,638		126,638			11
12	Social Services	96,483	3,842		100,325		100,325		100,325			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	<b>TOTAL Health Care and Programs</b>	3,591,532	85,770	112,914	3,790,216		3,790,216		3,790,216			16
	<b>C. General Administration</b>											
17	Administrative	58,465		41,518	99,983		99,983	(41,518)	58,465			17
18	Directors Fees											18
19	Professional Services			44,379	44,379		44,379		44,379			19
20	Dues, Fees, Subscriptions & Promotions			43,747	43,747		43,747	(26,085)	17,662			20
21	Clerical & General Office Expenses	168,895	30,366	26,078	225,339		225,339	(3,048)	222,291			21
22	Employee Benefits & Payroll Taxes			1,141,219	1,141,219		1,141,219	(5,558)	1,135,661			22
23	Inservice Training & Education											23
24	Travel and Seminar			13,459	13,459		13,459		13,459			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			45,457	45,457		45,457		45,457			26
27	Other (specify):*											27
28	<b>TOTAL General Administration</b>	227,360	30,366	1,355,857	1,613,583		1,613,583	(76,209)	1,537,374			28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,705,040	431,135	1,803,784	6,939,959		6,939,959	(77,757)	6,862,202			29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number

Rehab &amp; Care Ctr-Jackson County

#0010330

Report Period Beginning:

12/01/02

Ending:

11/30/03

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			341,075	341,075		341,075	(12,234)	328,841			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							(2,618)	(2,618)			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			341,075	341,075		341,075	(14,852)	326,223			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		407,307		407,307		407,307		407,307			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			110,595	110,595		110,595		110,595			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		407,307	110,595	517,902		517,902		517,902			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,705,040	838,442	2,255,454	7,798,936		7,798,936	(92,609)	7,706,327			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number Rehab &amp; Care Ctr-Jackson County

# 0010330

Report Period Beginning:

12/01/02

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## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,548)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(2,618)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(12,234)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(80)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(41,518)	17		24
25	Fund Raising, Advertising and Promotional	(26,085)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,526)	21,22		29
30	<b>SUBTOTAL (A): (Sum of lines 1-29)</b>	<b>\$ (92,609)</b>		<b>\$</b>	<b>30</b>

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	<b>SUBTOTAL (B): (sum of lines 31-35)</b>	<b>\$</b>		<b>36</b>
	<b>(sum of SUBTOTALS</b>			
37	<b>TOTAL ADJUSTMENTS (A) and (B) )</b>	<b>\$ (92,609)</b>		<b>37</b>

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	<b>TOTAL (C): (sum of lines 38-46)</b>			<b>\$</b>		<b>47</b>

## Rehab &amp; Care Ctr-Jackson County

ID# 0010330

Report Period Beginning: 12/01/02

Ending: 11/30/03

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Vending Income	\$ (5,558)	22	1
2	Postage	(176)	21	2
3	Copies	(1,326)	21	3
4	Miscellaneous	(1,466)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36			2	36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(8,526)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Rehab &amp; Care Ctr-Jackson County

# 0010330

Report Period Beginning:

12/01/02

Ending:

11/30/03

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,548)	0	0	0	0	0	0	0	0	0	0	(1,548)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(1,548)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,548)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(41,518)	0	0	0	0	0	0	0	0	0	0	(41,518)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(26,085)	0	0	0	0	0	0	0	0	0	0	(26,085)	20
21	Clerical & General Office Expenses	(3,048)	0	0	0	0	0	0	0	0	0	0	(3,048)	21
22	Employee Benefits & Payroll Taxes	(5,558)	0	0	0	0	0	0	0	0	0	0	(5,558)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>(76,209)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(76,209)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(77,757)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(77,757)</b>	<b>29</b>

## Summary B

Facility Name & ID Number	Rehab & Care Ctr-Jackson County	#	0010330	Report Period Beginning:	12/01/02	Ending:	11/30/03
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## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]



**VII. RELATED PARTIES**

**A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

**B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.**   
☐ YES   
☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

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Facility Name & ID Number      Rehab & Care Ctr-Jackson County      #      0010330      Report Period Beginning:      12/01/02      Ending:      11/30/03

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Rehab & Care Ctr-Jackson County # 0010330 Report Period Beginning: 12/01/02 Ending: 11/30/03

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1							\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Rehab & Care Ctr-Jackson County**# **0010330** Report Period Beginning: **12/01/02** Ending: **11/30/03****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2002 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1998	8		
	1999	9		
	2000	10		
	2001	11		
	2002	12		
			<b>FOR OHF USE ONLY</b>	
			13	FROM R. E. TAX STATEMENT FOR 2002 \$ 13
			14	PLUS APPEAL COST FROM LINE 5 \$ 14
			15	LESS REFUND FROM LINE 6 \$ 15
			16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2002 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Rehab & Care Ctr-Jackson County    COUNTY    Jackson

FACILITY IDPH LICENSE NUMBER    0010330

CONTACT PERSON REGARDING THIS REPORT    \_\_\_\_\_

TELEPHONE (    )    FAX #: (    )

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax Applicable to Nursing Home</u>
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		<b>TOTALS</b>	\$ <u>          </u>	\$ <u>          </u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?    \_\_\_\_\_ YES    \_\_\_\_\_ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.  
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

A. Square Feet:
 150,000

B. General Construction Type:
 Exterior
 Brick
 Frame
 Concrete and Steel
 Number of Stories
 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 \_\_\_\_\_

2. Number of Years Over Which it is Being Amortized:
 \_\_\_\_\_

3. Current Period Amortization:
 \_\_\_\_\_

4. Dates Incurred:
 \_\_\_\_\_

Nature of Costs:
 \_\_\_\_\_
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	871,200	1960	\$ 10,000	1
2					2
3	TOTALS	871,200		\$ 10,000	3

Facility Name &amp; ID Number Rehab &amp; Care Ctr-Jackson County

# 0010330

Report Period Beginning:

12/01/02

Ending:

11/30/03

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation
4	100	1960	1960	\$ 1,069,483	\$	30	\$	\$	\$ 1,069,483
5		1966	1966	289,003		30			288,995
6	102	1972	1972	1,404,551		30			1,404,530
7									
8									
<b>Improvement Type**</b>									
9	Parking Lots	1972		63,650		22.45			63,650
10	Building Improvements	1974		122,761		19.66			122,761
11	New Electric Cable	1979		7,903		15			7,903
12									
13	Sprinkler System	1978		1,005	40	24.51	40		1,002
14	Building Improvements	1978		31,978		21.01			31,978
15	Air Conditioning	1979		8,150		19.98			8,150
16	Landscaping	1981		315		10			315
17	Fire Doors	1981		352		20			352
18	Electrical Work	1981		9,584		20			9,584
19	Electrical Wiring	1981		12,896		20			12,896
20									
21	Air Compressor	1981		1,242		10			1,242
22									
23	Hot Water Heating System	1982		15,222		15			15,222
24	Door Closer	1982		650		15			650
25	Fire Doors	1982		5,288		15			5,288
26	Roof Repairs	1982		322,299		15			322,299
27	Electric Work	1983		100,430		15			100,430
28	Electric Panel Modification	1983		1,002		15			1,002
29	Roof Repairs	1983		38,573		15			38,573
30	Fire Doors	1983		1,158	27	20	27		1,158
31	Air Handling Units	1984		1,166		10			1,166
32	Booster Pump	1984		1,085		10			1,085
33	Key Locks and Building	1984		1,592		15			1,592
34	Ground fault Recepticles	1984		1,022		15			1,022
35	Roof Repairs	1984		121,210		15			121,210
36									

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	Fire Alarm System	1984	\$ 52,151	\$	15	\$	\$	\$ 52,151		37
38	Interior Aluminum Doors	1985	1,144	57	20	57		999		38
39	Storage Shed	1985	1,095	55	20	55		1,016		39
40	Exterior Doors	1985	1,635	82	20	82		1,434		40
41	Fire Doors	1985	3,822	191	20	191		3,534		41
42	Key Locks and Buildings	1985	359		15			359		42
43	Ceiling Tiles	1985	957		15			957		43
44	Building Repair	1985	1,999		15			1,999		44
45	Fire Alarm System	1985	1,086		15			1,086		45
46	Heating System	1985	137,183		15			108,616		46
47										47
48	Call Light System	1985	19,148		15			19,148		48
49	Heating System	1986	2,418	121	20	121		2,117		49
50	Generator	1986	28,546	1,427	20	1,427		24,974		50
51	Emergency Generator	1986	15,400	770	20	770		13,475		51
52	Roof Repairs	2002	279,610	18,656	15	18,656		20,209		52
53	Dietary Renovation-Conveyor	1987	5,083		15			5,083		53
54	Dietary Renovation-Refrig/Freezer	1987	25,083	1,254	20	1,254		20,691		54
55	A.B.& C Renovations	1987	337,164	16,858	20	16,858		278,158		55
56	Vinyl Flooring	1987	29,000	1,450	20	1,450		23,925		56
57	Dietary Renovations	1987	276,810	13,841	20	13,841		228,363		57
58	A.B.& C Renovations-Final	1988	1,521	76	20	76		1,178		58
59	Dietary Renovations	1988	815	41	20	41		634		59
60	Roof Repairs	1989	16,485	1,099	15	1,099		15,936		60
61	Transfer Switch	1989	6,425	321	20	321		4,656		61
62	Kickplates	1989	1,685	112	15	112		1,625		62
63	Laundry Renovations	1989	187,559	9,378	20	9,378		135,981		63
64	Sprinkler	1990	3,150	126	25	126		1,701		64
65	Lockers	1990	4,233	212	20	212		2,861		65
66	Earthquake Valves	1990	5,648	282	20	282		3,808		66
67	Security System	1990	1,798	120	15	120		1,620		67
68	Cubicle Track	1990	5,729	382	15	382		5,157		68
69	Screens	1991	1,804	120	15	120		1,501		69
70	TOTAL (lines 4 thru 69)		\$ 5,090,115	\$ 67,098		\$ 67,098	\$	\$ 4,618,490		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 5,090,115	\$ 67,098		\$ 67,098		\$ 4,618,490	1
2	Kickplates	1991	1,531	102	15	102		1,275	2
3	Medical Ancillary Center	1991	1,448	72	20	72		901	3
4	Boilers & Cooling Tower	1991	18,057	903	20	903		11,287	4
5	Asbestos Removal	1991	26,516		10			26,516	5
6	Hazmat Storage Building	1992	1,485	74	20	74		854	6
7	Boilers & Cooling Tower	1992	289,332	14,467	20	14,467		166,617	7
8	Asbestos Removal	1992	17,956		10			17,956	8
9	Engineering Study-Electrical Work	1992	16,098	805	20	805		9,257	9
10	Paging System	1993	4,385	292	15	292		3,067	10
11	Case Work Replacement	1993	85,585	4,279	20	4,279		44,931	11
12	Floor Tile/Vinyl Flooring/Fire Door	1993	34,880	1,744	20	1,744		18,312	12
13	Sealant	1993	16,150	646	25	646		6,783	13
14	Shelter	1993	7,995	400	20	400		4,198	14
15	Chain Link Fence	1993	4,990	333	15	333		3,493	15
16	Parking Lot	1993	29,310	1,954	15	1,954		20,517	16
17	Outside Lights	1993	18,839	1,256	15	1,256		13,187	17
18	Curbing & Sidewalks	1993	6,820	341	20	341		3,581	18
19	Sidewalk Extension	1994	4,999	250	20	250		2,375	19
20	Resurface & Striping	1994	1,543	103	15	103		977	20
21	HVAC System	1994	4,570	229	20	229		2,174	21
22	Boiler Room	1994	34,821	1,741	20	1,741		16,540	22
23	Floor Tile/Vinyl Flooring/Fire Door	1994	4,999	250	20	250		2,375	23
24	Masonry Work	1994	4,840	194	25	194		1,842	24
25	Sealant	1994	850	34	25	34		323	25
26	Visual Observation System	1994	60,480	4,032	15	4,032		38,304	26
27	Telephone System	1995	16,928	846	20	846		7,192	27
28	Boiler Room	1995	5,379	269	20	269		2,286	28
29	Safety Wire Glass	1995	2,600	173	15	173		1,472	29
30	Tuckpointing & Waterproofing	1996	1,800	72	25	72		540	30
31	Metal Fire Door	1996	1,785	89	20	89		669	31
32	Repair to Electric Facilities	1996	5,176	259	20	259		1,942	32
33	Shelving	1996	3,680	184	20	184		1,380	33
34	TOTAL (lines 1 thru 33)		\$ 5,825,942	\$ 103,491		\$ 103,491		\$ 5,051,613	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12B, Carried Forward		\$ 5,825,942	\$ 103,491		\$ 103,491		\$ 5,051,613		1
2	Fire Doors	1997	707	35	20	35		229		2
3	Counter Top-Gray Essences	1998	784	52	15	52		238		3
4	Carpet-Bus Off, NSG. Admin., Chapel	1998	4,047	192	5	192		4,047		4
5	Metal Fire Retardant Door-Dietary	1998	2,912	146	20	146		790		5
6	Fuel Tank Removal & Upgrade	1998	85,056	4,253	20	4,253		24,468		6
7	Side Rails	1998	2,697	180	15	180		1,040		7
8	Smokers' Shelter 10x21	1999	1,671	167	10	167		692		8
9	Patio	1999	1,000	100	10	100		439		9
10	Chain Link Fence Extension	1999	510	34	15	34		150		10
11	Ceiling Tiles	1999	557	70	8	70		301		11
12	Mini-Kitchen	2000	3,342	167	20	167		659		12
13	HVAC	2000	2,039,563	135,971	15	135,971		408,285		13
14	Patio	2000	2,612	261	10	261		848		14
15	Rollup Curtains-Cabana	2001	2,820	282	10	282		705		15
16	Landscaping	2001	3,283	328	10	328		711		16
17	Handrails(220LF)	2001	2,114	140	15	140		375		17
18	Ceiling Tiles	2001	1,689	113	15	113		282		18
19	Roof Repairs	2001	700	47	15	47		121		19
20	Window Pictorials for Cafeteria	2001	3,554	355	10	355		740		20
21	Floor Tile-E&F Solarium	2001	2,175	109	20	109		272		21
22	Floor Tile-D Unit	2001	7,265	363	20	363		908		22
23	Ceiling Tiles	2001	325	22	15	22		51		23
24	Floor Tile-E Unit	2001	7,510	376	20	376		880		24
25	Handrails(360 LF)	2001	3,515	234	15	234		527		25
26	Knoblocks (2-Corbin Grade 1 )	2001	564	38	15	38		85		26
27	Floor Tile-G Unit	2001	17,110	856	20	856		1,712		27
28	Steamer	2001	24,080	2,408	10	2,408		7,023		28
29	Marquee Sign	1995	4,491	449	10	449		3,816		29
30	Dining Room Curtains & Tension Rods	2002	563	113	5	113		207		30
31	Interior Fuse Panel with Breakers	2002	1,850	94	20	94		188		31
32	Supply Line for Steam Table	2002	377	19	20	19		33		32
33	Climate Control Basic Compressor 216QRBL	2002	1,029	69	15	69		69		33
34	TOTAL (lines 1 thru 33)		\$ 8,056,414	\$ 251,534		\$ 251,534		\$ 5,512,504		34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 8,056,414	\$ 251,534		\$ 251,534	\$	\$ 5,512,504	1
2	TV Wall Units	2003	840	168	5	168		168	2
3	Window Treatments	2003	703	141	5	141		141	3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 8,057,957	\$ 251,843		\$ 251,843	\$	\$ 5,512,813	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 870,122	\$ 72,068	\$ 72,068	\$	*5-20	\$ 596,832	71
72	Current Year Purchases	56,406	2,574	2,574		*3-20	2,420	72
73	Fully Depreciated Assets	731,506	2,356	2,356		*5-20	731,506	73
74								74
75	TOTALS	\$ 1,658,034	\$ 76,998	\$ 76,998	\$		\$ 1,330,758	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 9,725,991	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 328,841	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 328,841	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 6,843,571	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Medical Ancillary Complex 1990	\$ 107,276	\$ 5,364	\$ 72,413	86
87	HVAC Project	103,052	6,870	20,629	87
88					88
89					89
90					90
91	TOTALS	\$ 210,328	\$ 12,234	\$ 93,042	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ \_\_\_\_\_ Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ \_\_\_\_\_

13. /2005 \$ \_\_\_\_\_

14. /2006 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<p><b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b></p> <p><input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p><b>2. CLASSROOM PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p><b>3. CLINICAL PORTION:</b></p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	--	---

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist		hrs	\$		115
2	Licensed Speech and Language Development Therapist		hrs		384	15,051	249	384	15,300	2	
3	Licensed Recreational Therapist		hrs							3	
4	Licensed Physical Therapist	10a/8	2088	hrs	58,574	398	7,383	3,041	2,486	68,998	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	39/8	# of prescrpts				223,829		223,829		9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):   VA Lab, Med Supply						156,911		156,911		13
14	TOTAL			\$	58,574	897	\$ 26,356	\$ 385,121	2,985	\$ 470,051	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.



		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 604,463	\$	1
2	Cash-Patient Deposits	30,333		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 96,653 )	2,360,507		3
4	Supply Inventory (priced at )	6,500		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,009		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from other funds, Payroll	1,120,001		9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 4,122,813	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	166,648		13
14	Buildings, at Historical Cost	8,111,705		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,665,033		16
17	Accumulated Depreciation (book methods)	(6,882,491)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 3,060,895	\$	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 7,183,708	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 144,915	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	30,333		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	452,175		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Deferred Revenue	693,833		36
37	Accrued DPA Assessment	(9,393)		37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 1,311,863	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 1,311,863	\$	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 5,871,845	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 7,183,708	\$	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 6,283,151</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 6,283,151</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(411,306)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (411,306)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 5,871,845</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

Facility Name &amp; ID Number Rehab &amp; Care Ctr-Jackson County

# 0010330

Report Period Beginning: 12/01/02

Ending:

11/30/03

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,486,125	1
2	Discounts and Allowances for all Levels	(2,171,659)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 7,314,466	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	1,548	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,618	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 4,166	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	36,345	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 36,345	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	Miscellaneous	1,466	28
28a	Copies, Postage, Vending	7,186	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 8,652	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 7,363,629	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,536,160	31
32	Health Care	3,766,215	32
33	General Administration	1,613,583	33
<b>B. Capital Expense</b>			
34	Ownership	341,075	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	407,307	35
36	Provider Participation Fee	110,595	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 7,774,935	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(411,306)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (411,306)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? \_\_\_\_\_ If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

## STATE OF ILLINOIS

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Facility Name & ID Number Rehab & Care Ctr-Jackson County# 0010330Report Period Beginning: 12/01/02Ending: 11/30/03

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,070	2,088	\$ 61,398	\$ 29.41	1
2	Assistant Director of Nursing	2,070	2,088	50,518	24.19	2
3	Registered Nurses	41,168	41,657	798,412	19.17	3
4	Licensed Practical Nurses	20,951	21,238	550,873	25.94	4
5	Nurse Aides & Orderlies	125,339	126,492	1,657,245	13.10	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	2,072	2,088	58,574	28.05	7
8	Rehab/Therapy Aides	15,593	15,771	167,389	10.61	8
9	Activity Director	1,960	2,001	44,578	22.28	9
10	Activity Assistants	7,927	8,024	81,927	10.21	10
11	Social Service Workers	6,484	6,543	96,617	14.77	11
12	Dietician					12
13	Food Service Supervisor	4,146	4,176	47,408	11.35	13
14	Head Cook	2,083	2,088	39,574	18.95	14
15	Cook Helpers/Assistants	30,741	31,086	335,505	10.79	15
16	Dishwashers					16
17	Maintenance Workers	7,677	7,795	63,063	8.09	17
18	Housekeepers	17,048	17,251	224,085	12.99	18
19	Laundry	15,382	15,600	176,513	11.31	19
20	Administrator	2,049	2,088	58,465	28.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	2,040	2,088	44,256	21.20	23
24	Clerical	9,992	10,098	148,640	14.72	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	316,792	320,260	\$ 4,705,040 *	\$ 14.69	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	96	\$ 13,296		35
36	Medical Director	480	38,280		36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,400		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify) <u>Quality Assessment</u>		300		46
47	<u>Dental Consultant</u>	240	20,400		47
48	<u>Psych Consultat</u>		4,200		48
49	TOTAL (lines 35 - 48)	816	\$ 78,876		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Facility Name &amp; ID Number Rehab &amp; Care Ctr-Jackson County

# 0010330

Report Period Beginning: 12/01/02

Ending: 11/30/03

## XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		Amount
Name	Function	%		Description			Description		
Merle K. Taylor	Nursing Home Administrator	0	\$ 58,465	Workers' Compensation Insurance	\$ 135,741		IDPH License Fee	\$	
				Unemployment Compensation Insurance	10,403		Advertising: Employee Recruitment		2,343
				FICA Taxes	321,710		Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	566,580		Books and Subscription		1,927
				Employee Meals			Marketing		23,742
				Illinois Municipal Retirement Fund (IMRF)*	92,981		Licenses and Dues		12,200
				Employee Physical Exams	818		Chamber of Commerce Dues		275
				Employee Dental Ins	0		Sam's Club Membership		240
				Employee Relations	12,986		Illinois Dept of Public Health		3,020
							Less: Public Relations Expense		(23,742)
							Non-allowable advertising		(2,343)
							Yellow page advertising	(	
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 58,465				TOTAL (agree to Sch. V, line 20, col. 8)	\$	17,662
B. Administrative - Other				TOTAL (agree to Schedule V, line 22, col.8)		\$ 1,141,219			
Description			Amount	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
			\$	Description	Line #	Amount	Description		Amount
						\$	Out-of-State Travel	\$	1,049
							In-State Travel		959
							Mileage Paid for various employees for trael		2,247
							Seminar Expense		9,204
							Entertainment Expense	(	
							(agree to Sch. V, line 24, col. 8)	\$	13,459
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	TOTAL		\$			
C. Professional Services									
Vendor/Payee	Type		Amount						
Kerber, Eck, and Braeckel	Cost Report and Audit		4,875						
Duane Morris	Attorney Fees		36,793						
Jackson County	Salary		2,366						
FR&R Healthcare Consulting, Inc.	M'care Consulting		345						
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 44,379						

\* Attach copy of IMRF notifications

\*\*See instructions.

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).**

(See instructions.)

[illegible]

**XX. GENERAL INFORMATION:**

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. CNHA & IHCA \$12200
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? \_\_\_\_\_
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ N/A Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? \_\_\_\_\_  
If YES, give effective date of lease. No
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 110,595 Lic. Bed Tax  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ N/A Has any meal income been offset against related costs? \_\_\_\_\_ Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? None  
d. Have vehicle usage logs been maintained? N/A  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A  
**g. Does the facility transport residents to and from day training? No**  
**Indicate the amount of income earned from providing such transportation during this reporting period.** \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Kerber, Eck, & Braeckel LLP The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.